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MEDICARE REIMBURSEMENT POLICY AND TAX CONSIDERATIONS RELATING TO MERGERS AND ACQUISITIONS

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MEDICARE REIMBURSEMENT POLICY AND TAX CONSIDERATIONS RELATING TO MERGERS AND ACQUISITIONS

Introduction

On March 21, 1984, the Subcommittee on Health and the Subcommittee on Oversight of the Committee on Ways and Means held a hearing on the effects of changes in ownership on medicare costs. The joint hearing was called to examine the impact of mergers and acquisitions on medicare program costs.

The hearing focused on a report of the General Accounting Office, requested by the Honorable Bill Gradison and issued on December 22, 1983. The report, entitled "Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs," reviewed the acquisition of one large hospital chain by another. The report concluded that, during the first year after the acquisition, the overall costs of the acquired hospitals increased because of the acquisition by a net amount of about $55 million attributable to changes in interest, depreciation and home office expenses. A portion of the increased costs was allocated to the medicare and medicaid programs.

Under current medicare rules, when the ownership of a hospital changes hands, the new owner generally is permitted to revalue the acquired asset to reflect the actual purchase price, thus permitting the new owner to use a higher basis on which the asset can be depreciated. This may result in medicare paying for the asset a second time at a higher price.

Interest costs reimbursed by medicare may also increase. If the buyer borrows money to pay for the asset, medicare makes increased payments for increased interest costs. This results from the larger outstanding debt and higher interest rates. GAO concluded that the costs in one audited hospital had risen by $26 per day for medicare and $31 per day for medicaid as a result of the increased capital costs allocated to the hospital.

The GAO report identified questionable accounting practices which would increase program costs and also focused on several areas where medicare capital payment rules need clarification. In addition, GAO indirectly raised the question of whether medicare's current rules with respect to revaluation of assets are appropriate.

In addition to medicare's reimbursement rules, Federal tax laws can have a significant impact on the decision of one hospital to acquire the assets of another. The following summary describes both the current medicare reimbursement rules relating to mergers and acquisitions and the tax laws as they might affect the decision to purchase assets.

EXECUTIVE SUMMARY

The following description is intended as a brief review of present capital reimbursement policies under medicare and tax incentives for the purchase of depreciable property.

I. CAPITAL REIMBURSEMENT UNDER MEDICARE

Under present law and regulations, medicare pays hospitals and other providers of service for a portion of their capital-related costs on a reasonable cost basis. Capital-related costs are basically those facility costs associated with furnishing the buildings and equipment necessary to provide patient care. Present law provides that certain capital-related costs are excluded from the prospective payment system until October 1, 1986. Public Law 98–21, the Social Security Amendments of 1983, directs the Secretary of Health and Human Services to report to Congress on methods and proposals under which capital costs may be included in the prospective payment system.

Major Categories of Capital-Related Cost

1. Depreciation

Medicare recognizes depreciation as an element of capital cost payable by the program. Depreciation expenses are amounts which represent the portion of an asset's cost charged off to a particular period of operation, usually a year. In the case of hospitals, depreciable assets include: buildings, building equipment, major movable equipment, minor equipment, land improvements, and leasehold improvements made by the lessee.

Generally, in order to be recognized, depreciation must be: (1) identified and recorded in the provider's accounting records; (2) based on the historical cost of the asset (i.e., the cost incurred by the present owner in acquiring the asset); and (3) prorated over the useful life of the asset (minus salvage value).

In general, the estimated useful lives of assets developed by the American Hospital Association are recognized by medicare. Since 1970, medicare depreciation has been permitted on a straight-line basis only.

Present law and regulations also allow for a revaluation of the cost basis of any depreciable asset of a hospital or provider purchased as an ongoing operation in a bona fide sale. In addition to being the depreciable basis for the new owner, the revalued cost basis is also used to compute the amount of gain to the seller and to determine the figure from which the return on equity is calculated.

2. Interest

Necessary and proper interest on current and capital indebtedness is includable as an allowable cost under medicare. "Necessary" requires that the interest be incurred: (1) on a loan which is necessary to satis-

fy a financial need of the provider; (2) for purposes reasonably related to patient care; and (3) that the interest payment be reduced by investment income with certain exclusions. "Proper" requires that the rate of interest not exceed what a prudent borrower would have to pay in the money market in an arms-length transaction.

3. Return on Equity Capital

A reasonable return on equity (owner) capital invested and used in providing patient care is an allowable cost for proprietary, or for-profit, hospitals under medicare. The rate of return is equal to the rate of interest paid by the Federal Treasury on the assets of the Federal Hospital Insurance Trust Fund.

II. TAX INCENTIVES FOR THE PURCHASE OF DEPRECIABLE PROPERTY

For proprietary hospitals, medicare capital cost reimbursement exists side by side with tax treatment of capital costs. Current tax law may provide several incentives for businesses to acquire either for-profit or not-for-profit hospitals.

Investment in both new and used buildings and equipment is encouraged by the Accelerated Cost Recovery System (ACRS) created by the Economic Tax Recovery Act of 1981. ACRS generally allows owners of equipment to deduct its cost over a period of 3 or 5 years (depending on the nature of the asset) and to depreciate buildings over a period of 15 years. For most kinds of property, the depreciable life allowed for tax purposes is shorter than the asset's actual life. In addition, deductions may be accelerated. Investors in new equipment (but not buildings) may take an investment tax credit (that is, deduct directly from their tax bill) for up to 10 percent of the asset's purchase price.

Acquisition by a business of previously owned assets can trigger a second round of tax benefits. First, the purchaser may use the new purchase price as a basis for the purpose of calculating depreciation deductions. When costs are appreciating rapidly—as is the case with hospitals—then the buyer can obtain more generous tax treatment than the previous taxable owner of the same asset. If the seller was using the less generous depreciation system used for assets put in place before 1981, the buyer's tax treatment is even more advantageous than that of the seller.

The seller generally faces tax costs, but under some circumstances these may be minimal. Not-for-profit sellers pay no tax at all on the sale of assets. A proprietary owner that is purchased in its entirety (rather than divested of only some of its assets) and liquidates is taxed only on the "recapture" portion of its gain. That is, the gain on equipment is taxed, as ordinary income, only to the extent depreciation deductions were taken. (In addition, some investment tax credit may be recaptured.) The gain on buildings and improvements is taxed as ordinary income only to the extent previous deductions exceeded straight-line depreciation deductions (or to the extent of all depreciation in the case of buildings and improvements depreciated on an ac-

celerated basis under ACRS). Owners who depreciated buildings on a straight-line method face no tax at all on these buildings; others may face only a small tax.

A seller who sells only a portion of his assets pays tax at his regular income tax rate on the "recapture" portion of his gain. In addition, he pays tax generally at capital gains rates on the remainder of the gain.

The tax treatment of common financing mechanisms provides further benefits for the business acquisitions of depreciable property. The interest on debt is deductible from taxable income. Businesses may also use tax-exempt industrial revenue bonds (within limits) to finance the acquisition of hospitals.

OVERVIEW OF MEDICARE AND TAX LAW RELATING TO MERGERS AND ACQUISITIONS

I. CAPITAL-RELATED COST UNDER MEDICARE*

Under present law and regulations, medicare pays hospitals and other providers of services for a portion of their capital-related costs. Capital-related costs are basically those facility costs associated with furnishing the buildings and equipment necessary to provide patient care. Present law provides that certain capital-related costs (including depreciation, interest expense, leases, and rentals, and a return on equity capital in the case of profit-making entities) are reimbursable on a reasonable cost basis and excluded from medicare's prospective payment system for hospitals until October 1, 1986. Public Law 98–21, the Social Security Amendments of 1983, directs the Secretary of Health and Human Services to study and report to Congress on methods and proposals under which capital costs, including a return on equity, may be included under the prospective payment system.

Current regulations define certain capital costs that the Secretary recognizes as allowable for reimbursement purposes. Such costs must be reasonable and related to the provision of patient care. Reasonable costs include all necessary and proper expenses incurred in rendering services to beneficiaries. To be allowed, costs cannot exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Under medicare, the capital costs of participating hospitals are apportioned or divided between medicare program beneficiaries and the other patients using the facilities. This is accomplished through accounting methods which measure the use of hospital resources by medicare beneficiaries relative to the total use of hospital resources used by all patients served. Once determined, such amounts are paid to the facilities in addition to any amounts made under the prospective payment system for inpatient hospital services.

The specific categories of capital-related costs reimbursed by medicare are limited to the following:

1. Net depreciation expense adjusted by gains or losses realized from the disposal of the depreciable asset;
2. Taxes on land and/or depreciable assets used for patient care;
3. Leases and rentals for the use of depreciable assets;
4. Costs of betterments and improvements;
5. Costs of minor equipment that are capitalized;
6. Insurance expenses on depreciable assets;
7. Interest expenses;
8. For proprietary providers, a return on equity capital.

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*The portions of this print related to medicare reimbursement were prepared with the assistance of the staff of the Congressional Research Service.

Major Categories of Capital-Related Cost Reimbursed by Medicare

1. Depreciation

Medicare recognizes depreciation as an element of capital cost payable by the program. Depreciation expenses are amounts which represent the portion of an asset's cost that is charged off to a particular period of operation, such as an accounting period or reporting period (usually a year). In the case of hospitals, depreciable assets include: buildings, building equipment, major movable equipment, minor equipment, land improvements, and leasehold improvements made by a lessee.[1]

Depreciation accounting is a system of accounting which prorates the acquisition cost or other basic values of tangible assets less salvage value (if any) over the useful life of the asset.[2]

In general in order to be recognized the depreciation must be:

a. identifiable and recorded in the provider's accounting records;

b. based on the historical cost of the asset or fair market value of the asset at the time of donation in the case of donated assets (the historical cost is the cost incurred by the present owner in acquiring the assets);

c. prorated over the estimated useful life of the asset (the estimated useful life of an asset is its expected useful life to the hospital, not necessarily the asset's inherent useful life or physical life; in general the estimated useful lives developed by the American Hospital Association (AHA) are used by hospitals and accepted by the medicare program for determining depreciation);[3] and

d. since August 1, 1970, proration of the historical cost of an asset under medicare is generally allowed only on a straight-line basis (under this method, the historical cost of an asset (minus salvage value) is recovered by (and in the case of medicare, paid to) the hospital in equal amounts over the useful life of the asset).

Medicare does not require the funding of depreciation; that is, the hospital is not required to set aside the amount allowed for depreciation for replacement of depreciated assets, such as buildings or equipment. However, the regulations provide an incentive for funding of depreciation by providing that investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

The Economic Recovery Tax Act of 1981 (P.L. 97–34) made a number of changes in the calculation of depreciation for income tax purposes. However, the law excludes medicare (and other programs administered by the Secretary) from the new depreciation rules for purposes of determining cost reimbursement under the program.[4]

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[1] Land is not a depreciable asset.

[2] Salvage value is the estimated amount expected to be realized upon sale or disposition of a depreciable asset at the end of its useful life.

[3] For example, the AHA guidelines show a useful life of no more than 40 years for buildings. Fixed assets in the building, such as elevators, heating and air conditioning and plumbing, etc., have suggested useful lives of 10–20 years.

[4] The accelerated cost recovery system (ACRS) provisions adopted by Congress in 1981 to stimulate capital investments by permitting accelerated write-off of assets for income tax purposes do not apply to medicare. Section 203 of P.L. 97–34 indicated that the Secretary is "not required to apply any provisions of the Internal Revenue Code of 1954, as amended, in calculating depreciation (for the purposes of determining any cost under a program administered by the Secretary), unless a provision of the law requires so expressly." Medicare program officials announced that medicare reimbursement rules would not be modified to make them consistent with the ACRS recognized by the IRS for tax purposes.

The regulations allow for a change in the useful life of an asset. A provider may request a different useful life. The intermediary must approve the request, in writing, prior to becoming effective. If the request is approved, the change is effective with the reporting period immediately following the period in which the provider's request was submitted for approval.

The intermediary may approve the provider's request for a different useful life if the provider's request is properly supported by acceptable factors that affect the determination of useful life. Factors to be considered are: obsolescence due to normal economic or technological changes; climatic or other local conditions; and the provider's policy for repairs and replacement. However, such factors as an expected early retirement, demolition, or abandonment of an asset, or termination of a provider from the medicare program may not be used.[5]

Present law and regulations also allow for revaluation of the cost basis of any medicare depreciable assets of a hospital or other provider purchased as an ongoing operation in a bona fide sale. In addition to being the basis of depreciation for the new owner of the purchased assets, the revalued cost basis is also generally used to compute the amount of gain to the seller. The revalued cost basis may also be used as the figure from which return on equity (ROE) capital is calculated and the figure from which the amount of medicare allowed reimbursable interest expenses are determined.

The cost basis for depreciable assets of a hospital or other provider purchased as an ongoing operation in a bona fide sale on or after August 1, 1970, is limited by regulation to the lowest of the:

1. *Total price paid* for the facility by the purchaser, as allocated to individual assets;
2. *Total fair market value* of the facility at the time of the sale;
3. *Combined fair market value* of individually identified assets at the time of sale; or the
4. *Current reproduction cost* of the depreciable assets depreciated on a straight-line basis over the life of the assets to the time of sale.

Gains and losses realized from such sales are includable in allowable costs as an adjustment to depreciation claimed by the provider. The regulations provide that the amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously included in medicare allowed costs. The amount of loss included is limited to the undepreciated basis of the asset permitted under the program.[6] The treatment of such gains or losses depends upon the manner in which the depreciable assets is disposed. These include sale, scrapping, trade-in, demolition, abandonment or other casualty.

The following are examples of adjustments to depreciation due to gains or losses resulting from hypothetical sales of depreciable assets under medicare. Salvage values are disregarded for purposes of sim-

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[5] 42 CFR 405.415(b)(7)(i)(B), and (ii).

[6] The regulations stipulate specific rules for calculating the amount of these adjustments and for allocating the total amount of gains or losses to all reporting periods under the medicare program. (42 CFR 405.415(f)(2)–(6))

plicity. No particular share of medicare of any gain or loss is assumed for purposes of these illustrations.

Example 1. Depreciation recapture.—Consider an asset with a useful life of 10 years with a historical cost of $10 million. Assume the asset is sold at the end of 7 years for $8 million. Assume also that the sales price does not exceed fair market value or current reproduction cost.

	Millions
Historical cost	$10
Depreciation paid (7 years at $1 million/year)	7
Net book value (asset cost less accumulated depreciation)	3
Sales price	8
Less net book value	3
Gain to seller	5

Under current rules, medicare would recapture a share (calculated under special rules in the regulations for determining such amounts) of the $5 million gain to the seller. The program is entitled to share in such gains up to the amount of previously claimed depreciation.

The historical cost to the new owner would be the sales price, or $8 million. This would represent the new historical cost for determining medicare's future share of depreciation payments.

Example 2. Depreciation recapture where sales price exceeds historical cost.—Assume the same conditions as the preceding example, except that the sales price is $11 million (i.e., greater than the historical cost of the asset.)

	Millions
Historical cost	$10
Depreciation paid (7 years at $1 million/year)	7
Net book value (asset cost less accumulated depreciation)	3
Sales price	11
Less net book value	3
Gain to seller	8

Under current rules, medicare would recapture a share (calculated under special rules in the regulations for determining such amounts) of $7 million. The program may not recapture more than the amount of any previously claimed depreciation.

The historical cost to the new owner would be the sales price, or $11 million. This would represent the new historical cost for determining medicare's share of future depreciation payments.

Example 3. Depreciation adjustment involving loss to the seller.—Assume the same conditions as in the preceding examples, except that the sales price is $2 million (i.e., less than the remaining book value of the asset).

	Millions
Historical cost	$10
Depreciation paid (7 years at $1 million/year)	7
Net book value (asset cost less accumulated depreciation)	3
Sales price	2
Less net book value	3
Loss to seller	−1

Under current rules, medicare would share in the seller's loss (again calculated under the special rules for determining such amounts) of $1 million. The program shares in losses up to the undepreciated basis of reimbursable assets.

The historical cost to the new owner would be sales price, or $2 million. This would represent the new historical cost of determining medicare's future share of depreciation payments.

2. Interest

Necessary and proper interest on current and capital indebtedness is included as an allowable cost under medicare. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term, usually for such purposes as working capital. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as for an acquisition of facilities, equipment, or capital improvements. (42 CFR 405.419(b)(1))

"Necessary" requires that the interest be incurred (1) on a loan which is necessary to satisfy a financial need of the provider; (2) for purposes reasonably related to patient care; and (3) that the interest payment be reduced by investment income, *excluding* income from funded depreciation, gifts, grants, endowments, pension funds, and deferred compensation funds.

"Proper" requires that the rate of interest must not exceed what a prudent borrower would have to pay in the money market in an arms-length transaction. The interest must be paid to a lender not related through control or ownership or personal relationship to the borrowing organization.

For acquisitions occurring after July 1970, medicare's Provider Reimbursement Manual, section 203, establishes the method for determining the allocation of the interest on loans that are in excess of the asset value. The specific procedure, as explained in section 203, is as follows:

A. Where the loan is obtained to finance the purchase of a facility or a tangible asset that is acquired after July 1970, and the purchase price exceeds the historical cost or the cost basis, whichever is appropriate, interest expense on that portion of the loan used to finance the excess is not considered reasonably related to patient care and is not allowable;

B. The owner's investment in the acquisition of the facility or tangible assets is first applied to the tangible assets related to patient care, then to the intangible assets related to patient care, and lastly to tangible and intangible assets not considered related to patient care and goodwill;

C. Where the owner's investment is less than the cost allowed for the assets related to patient care, the interest on any additional funds borrowed applies first to the portion of the allowable cost of the intangible assets related to patient care not covered by the owner's investment, then to the intangible assets not considered reasonably related to patient care and goodwill;

D. Repayments of the funds borrowed are applied first to reducing the portion of the loan applied to the allowable cost of the patient

care assets, then to the tangible and intangible assets not considered reasonably related to patient care and goodwill.

Example: allocation of loan	
Purchase price of facility	$800,000
Allowable cost of facility for program purpose	600,000
Excess of purchase price over allowable program cost (i.e., less goodwill and assets unrelated to patient care)	200,000
Owner's investment in acquisition	350,000
Amount borrowed	450,000
Amount of loan on which interest is allowable:	
Allowable cost of facility	600,000
Less owner's investment	350,000
Interest expense allowable on loan of	250,000

3. Return on Equity Capital of Proprietary Hospitals

A reasonable return on equity (owner) capital invested and used in providing patient care is an allowable cost for proprietary, or for-profit, hospitals under medicare. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The base amount of equity capital to be used in computing the allowable return on equity is the average investment of the owners during a reporting period. The rate of return is equal to the rate of interest paid by the Federal Treasury on the assets of the Federal Hospital Insurance Trust Fund.

II. TAX INCENTIVES FOR THE PURCHASE OF DEPRECIABLE PROPERTY*

Introduction

This part describes provisions of the Internal Revenue Code generally applicable to acquisitions by businesses of new and used buildings, improvements and equipment. Included are the depreciation and investment tax credit provisions. Also included are provisions relating to debt financing, installment sales, tax-exempt obligations, and leasing. Finally, provisions relating to the acquisition of an entity as a whole (as contrasted with the acquisition of only some of the assets of the entity) are described.

Federal Income Tax Status of Health Care Providers

In general, health care providers may be tax-exempt organizations or taxable organizations under the Internal Revenue Code. Many health care providers qualify for tax-exempt status under section 501 (c) (3). That section exempts from Federal income taxation the income (other than the unrelated business taxable income) of a corporation organized and operated exclusively for charitable purposes if it also satisfies other requirements. Health care providers may also qualify

*Prepared by the staff of the Joint Committee on Taxation.

for tax exemption under other Code rules. For example, income from health care providers which are units of State and local governments is not taxable.

Many health care providers do not qualify for tax exemption under the Code. These health care providers are generally taxable like any other business. The difference between a taxable health care provider and a health care provider exempt from taxation under section 501 (c)(3) is likely to be that the former is engaging in business with the objective of earning a profit while the latter is not.

Depreciable Property

The Code provides tax benefits to persons acquiring depreciable property (i.e., certain property used in a trade or business). The benefits tend to be the greatest for property qualifying as recovery property under the Accelerated Cost Recovery System (ACRS) enacted as part of the Economic Recovery Tax Act of 1981 (ERTA). In general, recovery property is any depreciable property, new or used, placed in service by the taxpayer after December 31, 1980. However, recovery property does not include property acquired by the taxpayer in a sale-leaseback transaction if the lessee owned the property in 1980. The particular benefits depend on whether the property is personal property or real property.

1. Personal Property

Most personal property qualifying as recovery property is either 3-year property or 5-year property. Three-year property is personal property which (i) had a midpoint life under the Asset Depreciation Range (ADR) system (the depreciation system in effect prior to ERTA) of 4 years or less or (ii) is used in connection with research and experimentation. Most other personal property which qualifies as recovery property is 5-year property.

Three-year property can be depreciated over 3 years. For the year the property is placed in service (regardless of when during the year it is placed in service), 25 percent of its original cost (except as noted below) may be deducted. The percentages of original cost (except as noted below) which may be deducted in the second and the third year are 38 percent and 37 percent, respectively. Five-year property can be depreciated over 5 years. The maximum percentages of the property's original cost (except as noted below) which may be deducted in the first 5 years the property is in service are 15, 22, 21, 21, and 21 respectively.

The Code also allows investment tax credits with respect to new depreciable personal property placed in service by the taxpayer. For 3-year property, the credit is, in general, 6 percent of the original cost of the property. For 5-year property, the credit is, in general, 10 percent of its original cost. Investment credits are also available to some extent for certain used depreciable personal property placed in service by the taxpayer.

In general, investment credits reduce tax liability, dollar for dollar, in the year the property qualifying for the credit is placed in service by the taxpayer. However, investment credits reduce a property's original cost for depreciation purposes by one-half of the credit

amount. A taxpayer can elect a smaller credit in lieu of reducing the basis for depreciation purposes.

In general, when depreciable personal property, whether or not it constitutes recovery property, is sold at a gain, that gain is ordinary "recapture" income to the extent of any prior depreciation deductions taken. Any excess is generally treated as long-term gain. Furthermore, the sale of depreciable personal property, whether or not at a gain, may trigger recapture of investment credit with respect to that property. In general, a 2-percent credit is earned for each full year the property is in service. For example, if an item of 5-year property is sold during the third year after it was placed in service, a 6-percent credit generally would be recaptured and the amount added to the seller's tax liability for the year of sale.

2. Real Property

Most real property qualifying as recovery property, whether new or used, can be depreciated over a 15-year period. In general, a taxpayer can depreciate the property using an accelerated method of depreciation or the straight-line method. In either event, the depreciation deduction for any year with respect to any real property qualifying as recovery property depends on the number of months during such year the property was in service.

In general, when depreciable real property qualifying as recovery property is sold at a gain, the gain will generally be treated as long-term gain if the property was depreciated on the straight-line method. If it was depreciated on an accelerated method, the gain will be ordinary recapture income to the extent of any prior depreciation deductions taken. Any additional gain is generally treated as long-term capital gain.

Depreciable real property not qualifying as recovery property (e.g., property placed in service by a current user before January 1, 1981) is usually depreciated over its approximate real useful life, as determined under all the facts and circumstances (frequently 40 years for new property). Certain accelerated methods of depreciation are provided. Gain on a sale is generally treated as long-term capital gain unless an accelerated method was used. In the latter case, that part of the gain in excess of the depreciation allowed over what would have been allowed had the straight-line method been used is ordinary recapture income.

Financing

Present law provides tax benefits for various techniques of financing the acquisition of depreciable property.

1. Debt

Purchasers of depreciable property, including health care providers, often finance their purchases in part with money borrowed from banks or other financial institutions. Under the Code, interest on borrowed money is deductible when paid or accrued.

2. Installment Sales

Present law permits the seller of depreciable property on a deferred payment basis to defer paying any resulting tax liability until the deferred payments are received. The purchasers, however, can commence depreciation deductions immediately after the purchase, regardless of the amount of any payments then made.

3. Tax-exempt Financing

Interest on certain State and local obligations, including industrial development bonds, is not subject to Federal income taxation. Since the recipient is not taxable on the interest, the interest rate charged will be less than would otherwise be the case.

Taxable health care providers are permitted to borrow money on a tax-exempt basis in some circumstances, using industrial development bonds. There are limits imposed. Health care providers which are exempt from taxation under section 501(c)(3) or are parts of State or local governmental units are able to borrow money on a tax-exempt basis without substantial restrictions.[7]

4. Leasing

Tax-exempt health care providers, and taxable health care providers with substantial tax losses, are not in a position to make direct use of tax benefits available with respect to the acquisition of depreciable personal or real property. However, they can indirectly realize some of those tax benefits by leasing such property from lessors with taxes to pay, leaving the tax benefits with them. In general, the lessor will pass on to the lessee, in the form of reduced rents, some of the tax benefits associated with ownership of depreciable property.[8] This technique can be used for both new property and used property. Furthermore, the technique can be used with property already owned by the user, through a sale-leaseback transaction. Unless the lessee owned the property in 1980, the purchaser-lessor in such a sale-leaseback transaction will generally be entitled to depreciation deductions computed under ACRS.

Acquisitions of Other Health Care Providers

Some of the tax costs of selling depreciable property discussed above can be eliminated if a health care provider is acquired as a whole (as contrasted with an acquisition of only some of its assets). This relief is available if all the assets of a corporate health care provider are acquired and, as a part of the transaction, it liquidates, or if all the stock of a health care provider is acquired and it makes an election under section 338. In either such case, the health care provider would be taxed on depreciation recapture and investment credit recapture, if otherwise applicable, but not on any appreciation in the value of its assets treated as capital gain and thus not subject to depreciation recapture.

Conclusion: Tax Incentives to Acquire Existing Assets

In many instances, present law can provide significant tax incentives for the acquisition by another health care provider of the assets or stock of a health care provider with appreciated depreciable property. In general, these tax incentives include an option to increase the tax basis of the acquired company's depreciable property to its fair market value and to turn property not qualifying as recovery property into recovery property. In short, the buyer, by election, may be en-

[7] H.R. 4170, approved by the Committee on Ways and Means, would not change this rule in any material respect.

[8] Present law generally disallows investment credit on property leased to tax-exempt entities. H.R. 4170 would reduce depreciation tax benefits with respect to property leased to tax-exempt organizations, including State and local governmental units. An exception to the rule reducing depreciation would be made for high-technology medical equipment.

titled to larger depreciation deductions with respect to the seller's property than the seller would have been had it not sold the property.

For example, assume that a health care provider owns only one asset, a building with a fair market value of $1,000 and an adjusted basis of $100. Assume that the building is not recovery property in its hands. If another health care provider buys the asset in 1984 for $1,000 cash, it will obtain a $1,000 depreciable basis in the property. Furthermore, the building will become recovery property in the buyer's hands, qualifying for write-off over 15 years. Similar results can be achieved by election, if the buyer buys the stock of the seller rather than its assets. For the most part, these benefits are significant only if the buyer is a taxable organization.

These incentives for a buyer to acquire used property are often offset by disincentives for the owner to sell the property. If the seller of real property is a taxable organization, it will realize capital gain on the difference between the selling price and the adjusted basis of the property ($900 in the above example), unless it had taken accelerated depreciation. In the latter case, it would have ordinary recapture income. It will often be the case with non-ACRS property that the seller has used accelerated depreciation but the property's fair market value will substantially exceed its original cost to the seller. In such a case, the amount of recapture would be relatively small.

The property sold may include depreciable personal property. To the buyer, the tax consequences are about the same as above. It will obtain a fair market value basis in the property (and perhaps an investment credit for used property). Furthermore, the property will qualify as recovery property in the buyer's hands. If the seller is a taxable organization, investment credit taken on the property may be recaptured in whole or in part depending on how long it was held by the seller. Furthermore, the seller will have ordinary recapture income generally equal to the amount of any depreciable deductions taken on the property.

In several situations, the tax liability to the seller upon sale of the property is less than that described in the previous paragraphs. First, if the seller is a tax-exempt organization, it will have no tax consequences from the sale. Second, if the assets are purchased through an acquisition of the selling entity, rather than individual assets, the purchaser may elect that any capital gain on the assets may be excluded from tax, even though the purchaser may begin depreciation on the purchased assets using as a basis the fair market value of the property at the time of the purchase. (In such a case, the selling corporation would continue to be liable for recapture amounts and selling shareholders would be liable for tax on any capital gain realized on their stock at the time of sale.)

In sum, the tax system may provide incentives to the buyer of existing property and disincentives to the seller. Whether the incentives to the buyer outweigh the disincentives to the seller generally depends on the particular circumstances involved, such as the type and value of the property, the form of financing, and the form of the transaction (purchase of assets vs. purchase of entity). In two cases, however, the disincentives to such a purchase may be particularly low; these are an acquisition of an entire entity, which allows for exclusion of capital gain from corporate-level tax, and a sale by a tax-exempt organization.

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